Medical Marijuana Program
MONTHLY REMITTANCE FORM
(Please Print)

Instructions: Within 60 calendar days after the end of the remittance month, please submit the following identification card activity information along with a check or money order for the California Department of Health Services' (CDHS) portion of the fees collected.

SECTION 1	**SECTION 2**
Name of county	Remittance period (month/year)

SECTION 3	**SECTION 4**	**SECTION 5**
Name of county contact	Telephone number ( )	E-mail address

SECTION 6

Total state fees collected for all approved applications for this remittance period (as reported on the attached CDHS Report "County Fee Report" for the comparable remittance period): $

SECTION 7 DENIED NEW APPLICATION FEES FOR THIS REMITTANCE PERIOD.

A. Number of full fees collected	B. Total amount $
C. Number of Medi-Cal fees collected	D. Total amount $

SECTION 8 DENIED RENEWAL APPLICATION FEES FOR THIS REMITTANCE PERIOD.

A. Number of full fees collected	B. Total amount $
C. Number of Medi-Cal fees collected	D. Total amount $

SECTION 9

Grand total amount submitted for this remittance period (sum of Sections 6, 7B, 7D, 8B, 8D)

$

SECTION 10

Printed name of county contact

Signature of county contact Date

Section 11

If you have questions, please contact the Medical Marijuana Program Unit at (916) 552-8600. Please make check or money order payable to the California Department of Health Services and submit with this remittance form and completed CDHS report "County Fee Report" for the comparable remittance period to:

California Department of Health Services
Remittance Desk, Office of County Health Services
Medical Marijuana Program Unit
MS 5203
P.O. Box 997413
Sacramento, CA 95899-7413